DEPARTMENT OF PUBLIC HEALTH
AND HUMAN SERVICES

CHAPTER 83

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Subchapter 1 reserved

Subchapter 2

Eligibility Requirements for Qualified Medicare Beneficiaries

37.83.201 QUALIFIED MEDICARE BENEFICIARIES, APPLICATION AND ELIGIBILITY FOR MEDICAID (1) A person is a qualified medicare beneficiary eligible for medicaid, as provided for in Title 37, chapter 83, subchapter 8, if the person:

(a) is entitled to medicare Part A benefits as provided for in 42 USC 1395c et seq.;

(b) meets the nonfinancial criteria in (3) of this rule;

(c) has countable resources not in excess of two times the resource limitation applicable to the federal supplemental security income (SSI) resource limitation at 42 USC 1382a. The department hereby incorporates 42 USC 1382a as amended through April 1, 1989, which sets forth the resource limitation applicable to the federal (SSI) program. Copies of 42 USC 1382a, as amended through April 1, 1989, are available from the Department of Public Health and Human Services, Human and Community Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951; and

(d) has countable income as determined in accordance with this section;

(i) countable income may not exceed:

(A) 100% of the federal poverty income standard for state fiscal year 1991 and 1992;

(B) 110% of the federal poverty income standard for state fiscal year 1993 and 1994; and

(C) 120% of the federal poverty income standard for state fiscal year 1995 and years thereafter.

(2) When determining countable income, cost of living increases to the client's Title II social security benefits beginning with December of the previous year through the month after the official federal poverty standards are published shall be excluded.

(3) The non-financial criteria for determining eligibility of a medicaid qualified medicare beneficiary are that the person:

(a) is categorically eligible under the federal social security act as being:

(i) age 65 or older,

(ii) blind, or

(iii) disabled;

(b) has a social security number;

(c) meets the citizenship or alienage requirements of ARM 37.82.401; and

(d) meets the residency requirements of ARM 37.82.402.

(4) A person in applying for and receiving medicaid as a qualified medicare beneficiary is subject to the following provisions:

(a) ARM 37.85.407 concerning third party liability;

(b) ARM 37.82.201 concerning application requirements;

(c) ARM 37.82.204 concerning determinations of eligibility, except as to the effective date provided for at ARM 37.83.202;

(d) ARM 37.82.205 concerning redetermination;

(e) ARM 37.82.407 concerning limitation on the financial responsibility of relatives;

(f) ARM 37.82.415 concerning application for other benefits; and

(g) ARM 37.82.416 concerning assignment of rights to benefits.

(5) Countable income and resources will be determined using SSI criteria incorporated by reference in ARM 37.82.903 (2).

(6) No retroactive coverage is available to a person for medicaid services provided to the person as a qualified medicare beneficiary. If otherwise eligible for medicaid under another category, a person may receive retroactive coverage for medicaid services received through that other eligibility.

(7) A person receiving medicaid as a qualified medicare beneficiary must report within 10 days any changes in circumstances that may affect eligibility. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; AMD, 1990 MAR p. 1336, Eff. 7/13/90; AMD, 1992 MAR p. 674, Eff. 3/27/92; TRANS, from SRS, 2000 MAR p. 197.)

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37.83.202 QUALIFIED MEDICARE BENEFICIARIES, EFFECTIVE DATE OF ELIGIBILITY (1) A person is eligible for the receipt of medicaid benefits at the beginning of the following month after the department determines that the person is a qualified medicare beneficiary. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 197.)

Subchapter 3 reserved

Subchapter 4

Medicaid for Qualified Disabled Working Individuals

37.83.401 QUALIFIED DISABLED WORKING INDIVIDUALS, APPLICATION AND ELIGIBILITY FOR MEDICAID (1) A qualified disabled working individual (QDWI) is an individual:

(a) who is entitled to enroll in hospital insurance benefits (medicare Part A) under 42 USC 1395i-2a because he lost premium-free Part A medicare coverage due solely to excess earned income from substantial gainful activity;

(b) meets the non-financial criteria in (2) of this rule;

(c) whose income does not exceed 200% of the official federal poverty guideline as defined by the executive office of management and budget; and

(d) whose resources do not exceed twice the supplemental security income (SSI) resource limit set forth at 42 USC 1382 (a)(3)(A) and (B) (1990 edition).

(2) The non-financial criteria for determining eligibility of a qualified disabled working individual are that the person:

(a) has not attained the age of 65;

(b) is blind or disabled as defined in 42 USC 416(i)(1) (1990 edition).

(c) has a social security number;

(d) meets the citizenship or alienage requirements of ARM 37.82.401; and

(e) meets the residency requirements of ARM 37.82.402.

(3) A person in applying for and receiving medicaid as a qualified disabled working individual is subject to the following provisions:

(a) ARM 37.85.407 concerning third party liability;

(b) ARM 37.82.201 concerning application requirements;

(c) ARM 37.82.204 concerning determinations of eligibility;

(d) ARM 37.82.205 concerning redetermination;

(e) ARM 37.82.407 concerning limitation on the financial responsibility of relatives;

(f) ARM 37.82.415 concerning application for other benefits; and

(g) ARM 37.82.416 concerning assignment of rights to benefits.

(4) Countable income and resources will be determined using SSI criteria incorporated by reference in ARM 37.82.903 (2).

(5) A person receiving medicaid as a qualified disabled working individual must report within 10 days any changes in circumstances that may affect eligibility. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1991 MAR p. 1052, Eff. 7/1/91; TRANS, from SRS, 2000 MAR p. 197.)

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37.83.402 QUALIFIED DISABLED WORKING INDIVIDUALS, EFFECTIVE DATE OF ELIGIBILITY (1) A person is eligible for QDWI benefits as of the date that all eligibility criteria set forth in ARM 37.83.401 are met and he is enrolled in medicare Part A under 42 USC 1395i-2a.

(2) Retroactive coverage is available for up to 3 months prior to date of application. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1991 MAR p. 1052, Eff. 7/1/91; TRANS, from SRS, 2000 MAR p. 197.)

Rules 03 through 05 reserved

37.83.406 QUALIFIED DISABLED WORKING INDIVIDUALS, MEDICAID BENEFITS (1) Medicaid benefits for a qualified disabled working individual are limited to payment of the monthly medicare hospital insurance (Part A) premium. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1991 MAR p. 1052, Eff. 7/1/91; TRANS, from SRS, 2000 p. 197.)

Subchapter 5

Specified Low Income Medicare Beneficiaries

37.83.501 SPECIFIED LOW INCOME MEDICARE BENEFICIARIES, APPLICATION AND ELIGIBILITY FOR MEDICAID (1) A person is a specified low income medicare beneficiary eligible for medicaid as provided in (7) of this rule if the person:

(a) is entitled to medicare Part A benefits as provided in 42 USC 1395c et seq.;

(b) meets the nonfinancial criteria in (3) of this rule;

(c) has countable resources not in excess of two times the resource limitation applicable to the federal supplemental security income (SSI) resource limitation at 42 USC 1382a; and

(d) has countable income as determined in accordance with this section;

(i) countable income may not be less than 100% of the federal poverty income standard nor more than:

(A) 110% of the federal poverty income standard for calendar year 1993; and

(B) 120% of the federal poverty income standard beginning January 1, 1994.

(2) When determining countable income, cost of living increases to the client's Title II social security benefits shall be excluded from December of each year through the month after the official federal poverty standards are published.

(3) The non-financial criteria for determining eligibility of a medicaid specified low income medicare beneficiary are that the person:

(a) is categorically eligible under the federal Social Security Act as being:

(i) age 65 or older;

(ii) blind; or

(iii) disabled;

(b) has a social security number;

(c) meets the citizenship or alienage requirements of ARM 37.82.401; and

(d) meets the residency requirements of ARM 37.82.402.

(4) A person in applying for and receiving medicaid as a specified low income medicare beneficiary is subject to the following provisions:

(a) ARM 37.82.201 concerning application requirements;

(b) ARM 37.82.204 concerning determinations of eligibility;

(c) ARM 37.82.205 concerning redetermination of eligibility; and

(d) ARM 37.82.407 concerning limitation on the financial responsibility of relatives.

(5) Countable income and resources will be determined using SSI criteria incorporated by reference in ARM 37.82.903 (2).

(6) A person receiving medicaid as a specified low income medicare beneficiary must report within 10 days any changes in circumstances that may affect eligibility.

(7) Medicaid coverage for a person eligible for medicaid only as a specified low income beneficiary shall be limited to payment of medicare Part B premiums.

(8) A specified low income medicare beneficiary may be eligible for retroactive coverage for any or all of the 3 months immediately preceding the month of application, if the applicant met all of the financial and non-financial criteria set forth in (1)(a) through (5) of this rule in that month. (History: Sec. 53-2-201, 53-6-111 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1993 MAR p. 1542, Eff. 7/16/93; TRANS, from SRS, 2000 MAR p. 197.)

Subchapters 6 and 7 reserved

Subchapter 8

Requirements for Qualified Medicare Beneficiaries

37.83.801 MEDICAID COVERAGE FOR QUALIFIED MEDICARE BENEFICIARIES (1) ARM Title 37, chapter 83 implements medicaid coverage, as provided for in Section 301 of the Medicare Catastrophic Coverage Act of 1988 and House Bills 452 and 453 of the 51st Montana legislature for the costs of medicare Parts A and B insurance premiums, deductibles, and coinsurance for persons who are categorically entitled to medicaid and meet certain financial and other criteria. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 197.)

37.83.802 QUALIFIED MEDICARE BENEFICIARIES, DEFINITIONS

(1) "Assignment" means an agreement between the medicare carrier and a medicare provider under which the carrier makes payment to the provider rather than the recipient, and the provider agrees to accept the medicare allowable rate as payment in full.

(2) "Carrier" means the private insurance company contracted with by the United States health care financing administration to process medicare Part B claims and issue payments to physicians and other providers or to recipients.

(3) "Chiropractic services" means the manipulation of the spine by a licensed chiropractor to correct a subluxation. Chiropractic services do not include x-rays or other diagnostic or therapeutic services provided by a licensed chiropractor.

(4) "Coinsurance" means an amount of medical and other costs incurred by an eligible person that are the financial responsibility of that person rather than of the medicare Parts A or B insurance. The amount of coinsurance is the difference between the medicare allowable rate and the actual medicare payment.

(5) "Copayment" means a cost sharing fee imposed upon a qualified medicare beneficiary recipient for a medical service paid for by medicaid.

(6) "Customary charge" means the charge most frequently used by the provider for the service or item.

(7) "Deductible" means a set amount of medical and other costs designated by medicare as the person's financial responsibility. Medicare coverage begins with costs in excess of the deductibles.

(8) "Department" means the department of public health and human services as provided for at 2-15-2201, MCA.

(9) "Full medicaid" means medicaid coverage other than that provided to qualified medicare beneficiaries.

(10) "Hospice care" are those services providing pain relief, symptom management, respite care, and support services to terminally ill persons.

(11) "Intermediary" means the private insurance company contracted with by the United States health care financing administration to make coverage and payment decisions on services covered by medicare Part A insurance in hospitals, skilled nursing facilities, home health agencies and hospices.

(12) "Medicare allowable rate" means the reasonable charge for the medical service reimbursable under medicare Part B.

(13) "Medicare" means the health insurance programs under Title XVIII of the Social Security Act.

(14) "Medicare Part A insurance" means the insurance program under medicare that covers inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care.

(15) "Medicare Part B insurance" means the insurance program under medicare that covers outpatient hospital services, physician services, home health care services, and other medical services not covered by medicare Part A insurance.

(16) "Premiums" means the monthly amounts that are charged for a person to receive medicare Part B insurance coverage and that may be charged for a person to receive medicare Part A coverage when the person is not eligible for premium-free coverage.

(17) "Prevailing charge" means a level equal to at least three-fourths of the average of all the charges for the same service billed by all the physicians or suppliers in the state.

(18) "Qualified medicare beneficiary" means a person eligible for the program provided for in Title 37, chapter 83.

(19) "Respite care" is a short term inpatient hospital stay necessary to temporarily relieve the person who regularly provides hospice care to a person. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 197; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01.)

Rules 03 and 04 reserved

37.83.805 QUALIFIED MEDICARE BENEFICIARIES, GENERAL REQUIREMENTS (1) A qualified medicare beneficiary is subject to the requirements in the following rules:

(a) ARM 37.86.5303 concerning prior approval and restrictions on provider; and

(b) ARM 37.82.206 concerning the provisions of assistance. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113, 53-6-116 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 197; AMD, 2004 MAR p. 1624, Eff. 7/23/04.)

Rules 06 through 09 reserved

37.83.810 QUALIFIED MEDICARE BENEFICIARIES, PAYMENT OF MEDICARE PREMIUMS (1) Medicaid will cover the medicare Part B insurance premium for a qualified medicare beneficiary.

(2) Medicaid will cover the medicare Part A insurance premium for a qualified medicare beneficiary who is not eligible for premium-free medicare Part A insurance coverage.

(3) The department will enroll all qualified medicare beneficiaries in medicare Part B insurance. Persons who are not eligible for premium free medicare Part A insurance, will not be enrolled by the department in medicare Part A insurance. Those persons must enroll themselves through the United States social security administration. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 197.)

37.83.811 QUALIFIED MEDICARE BENEFICIARIES, COVERAGE OF DEDUCTIBLES AND COINSURANCE FOR MEDICARE SERVICES ALSO COVERED BY FULL MEDICAID (1) For a qualified medicare beneficiary, medicaid will participate in the deductibles and coinsurance for the following medicare services also covered by medicaid:

(a) inpatient hospital services;

(b) outpatient hospital services;

(c) home health services;

(d) skilled nursing home care;

(e) hospice care;

(f) outpatient physical therapy services;

(g) outpatient speech therapy services;

(h) outpatient occupational therapy services;

(i) prosthetic devices, durable medical equipment and medical supplies;

(j) physician services, including laboratory and x-ray services; and

(k) dental services which are oral surgery services.

(2) Medicaid requirements governing the services in (1) are found in Title 37, chapters 40, 82 and 86 of the Administrative Rules of Montana (ARM). Medicare requirements prevail when medicare requirements as to the availability and delivery of services differ from those for medicaid. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 197; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01.)

37.83.812 QUALIFIED MEDICARE BENEFICIARIES, PAYMENT FOR CHIROPRACTIC SERVICES AS MEDICARE SERVICES NOT COVERED BY FULL MEDICAID (1) Chiropractic services are a medicaid covered service for a qualified medicare beneficiary when the subluxation is demonstrated by x-ray to exist. The x-ray must be taken and interpreted by a doctor of medicine or osteopathy.

(2) Reimbursement for chiropractic services is the lowest of:

(a) the provider's submitted charge; or

(b) the medicaid fee for the service.

(3) These requirements are in addition to those in Title 37, chapter 85, subchapter 4 of the Administrative Rules of Montana (ARM). (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 197; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01.)

Rules 13 through 19 reserved

37.83.820 QUALIFIED MEDICARE BENEFICIARIES, FREE CHOICE OF PROVIDERS (1) Any qualified medicare beneficiary may obtain services from any institution, agency, pharmacy, or practitioner licensed and qualified to perform such services and participating under the medicaid program, unless the department restricts the person's access to services as provided for in ARM 37.86.5303. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-113, 53-6-116 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 197; AMD, 2004 MAR p. 1624, Eff. 7/23/04.)

37.83.821 QUALIFIED MEDICARE BENEFICIARIES, PROVIDER REQUIREMENTS (1) As a condition of participation in the Montana medicaid program, including the qualified medicare beneficiary program, all providers of service shall abide by all applicable state and federal statutes and regulations, including but not limited to federal regulations and statutes found in Title 42 of the United States Code and the Code of Federal Regulations governing the medicaid program, and all pertinent Montana statutes and rules governing licensure and certification.

(2) In addition to the requirements provided in these rules, a provider of services to a medicaid qualified medicare beneficiary must comply with the requirements in the following rules:

(a) ARM 37.85.402 concerning provider requirements, participation and service delivery;

(b) ARM 37.85.406(1) concerning billing requirements;

(c) ARM 37.85.406(2) concerning prompt payment of claims and prompt recovery of all payments erroneously or improperly made to a provider;

(d) ARM 37.85.406(3) and (4) concerning reimbursement requirements, payment in full and retroactive payment increases;

(e) ARM 37.85.406(5), (6) and (7) concerning direct provider payments, payment rates for out of state providers and governmental billing of medicaid;

(f) ARM 37.85.407 concerning third party liability;

(g) ARM 37.85.414 concerning record keeping, record disclosure and audits; and

(h) ARM 37.85.501 concerning sanctions. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 197.)

37.83.822 QUALIFIED MEDICARE BENEFICIARIES, PROVIDER CHOICE OF PARTICIPATION AND OTHER RIGHTS (1) A provider may choose to provide services to a person either as a private pay client or as a medicaid client. A medicaid client is a person who is medicaid eligible either as a qualified medicare beneficiary or as a qualified medicare beneficiary who is also eligible under another medicaid category.

(2) A provider has the rights set forth in ARM 37.85.411, concerning the exercise of professional judgment, management of business affairs and a provider's right to appeal an administrative decision. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 197.)

Rules 23 and 24 reserved

37.83.825 QUALIFIED MEDICARE BENEFICIARIES, PAYMENTS TO PROVIDERS (1) Payments for services provided to medicaid qualified medicare beneficiaries may only be made to a provider. A provider in order to receive payments must be enrolled in the medicaid program.

(a) Medicaid payment will be made to the provider even when the provider for medicare purposes has not accepted assignment.

(2) Payment in full, except as otherwise provided in (2)(a) below, for services provided to medicaid qualified medicare beneficiaries, is the medicaid payment as determined under ARM 37.83.811, 37.83.812 and 37.85.406 plus the qualified medicare beneficiary's copayment as provided for in ARM 37.83.826. A provider may not collect any amount from the person which is in excess of payment in full even if that payment is less than the medicare insurance deductibles and coinsurance. Where a person is eligible for medicaid under both medicaid qualified medicare beneficiary and another medicaid category, a provider must accept the medicaid payment as payment in full.

(a) Where a provider does not accept medicare assignment and the person receiving medicaid services is medicaid eligible only as a qualified medicare beneficiary, the provider may bill the person for that portion of the service cost that is the difference between medicare's allowable rate and the provider's charge. A provider who does not accept medicare assignment must inform a person receiving services that this portion may be billed to the person.

(3) Subject to the requirements of this rule, the Montana medicaid program pays the lowest of the following for qualified medicare beneficiary services:

(a) the provider's usual and customary charge for the service; or

(b) the appropriate medicaid allowed amount as provided in ARM 37.85.406(18). (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 197; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01.)

37.83.826 QUALIFIED MEDICARE BENEFICIARIES, COPAYMENTS

(1) A qualified medicare beneficiary is responsible for copayments to the same extent as a medicaid recipient under the provisions of ARM 37.85.204. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; AMD, 1997 MAR p. 820, Eff. 5/6/97; AMD, 1997 MAR p. 1208, Eff. 7/8/97; TRANS, from SRS, 2000 MAR p. 197.)

Rules 27 through 29 reserved

37.83.830 QUALIFIED MEDICARE BENEFICIARIES, BILLING

(1) The requirements for billing medicaid are as follows:

(a) Claims for qualified medicare beneficiaries must be submitted to medicare first.

(i) Claims for medicare Part A insurance services must be submitted to the medicare Part A insurance intermediary for medicare payment and then submitted to medicaid on the appropriate claim form with the medicare explanation of medical benefits (EOMB) attached for payment of the deductibles and coinsurance.

(ii) Claims for medicare Part B insurance services must be submitted to the medicare Part B insurance carrier for medicare payment and then submitted to medicaid on the appropriate claim form with the medicare explanation of medical benefits (EOMB) attached for payment of the deductibles and coinsurance. The Part B carrier may, under an agreement with the department, submit the claims by electronic media to medicaid for payment of the deductibles and coinsurance. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 197.)

37.83.831 QUALIFIED MEDICARE BENEFICIARIES, DETERMINATION OF MEDICAL NECESSITY (1) For services to qualified medicare beneficiaries, medicaid may accept medicare's determination of medical necessity for services which require approval prior to service delivery or review prior to payment. Medicaid may also accept medicare's determination of whether a medical procedure is experimental or not.

(2) The department will only pay for medically necessary, non-experimental services, as established in ARM 37.82.102(2) and ARM 37.85.410. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-131, MCA; NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 197.)

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